SHAW ASSIST

Select a date and time for us to contact your client:

Date: _____ Time: ○ 9 ○ 10 ○ 12 ○ 2 ○ 4

Client's Name: _____

DOB: _____ Sex (Circle): M○ F○ State of Residence: _____

Phone Numbers: Cell _____ Home _____ Business _____

Email Address: _____

Carrier: _____

Face Amount: $ _____ Plan of Insurance: _____

Class Quoted: _____ Premium Quoted: $ _____

Riders: _____

Reservation for Medical Examination:

1st Choice Date: _____ Time: _____:_____ AM PM

2nd Choice Date: _____ Time: _____:_____ AM PM

Advisor Name (Please Print): _____

Cell Number: _____ Last Four Digits SSN: _____

How long have you known the client? Just Met or ___ Years

Promo Code (if applicable) _____

By initialing here _____, I agree to the following: by submitting this form, I consent to reviewing and verifying the contents of parts 1 and 2 of the application completed by third parties. Unless I request otherwise, these third parties are free to contact the proposed insured for any additional underwriting information required to complete this transaction. Also, I am confirming I provided my client with the appropriate HIPAA requirement, and if the policy is corporately owned, the client was informed of 101j requirements, and they were satisfied.

Fax: 888-329-7429 or email: email@shawamerican.com Phone: 800-626-5888

Please submit a copy of the illustration you presented to the client with this form. You ¬must be licensed in the client's state of residence. If you are not, let us know, and we can help you get licensed prior to the application.

Shaw American Financial Corp. Authorization for Release of Information

For the purpose of obtaining the insurance coverage that I have requested, I hereby authorize **Shaw American Financial Corp** and its affiliated agencies, including but not limited to APPs, Examination Management Services (EMSI), Exam One, Express Imaging Services, Jet Stream, Superior Mobile Medics, Employee Pooling, Shaw American Financial Corp/LifeMark Partners staff physician, LifeMark Partners to disclose my personal financial and health information to the insurance companies listed below. I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, Pharmacy Benefit Manager, pharmacy related service organization or other health care provider that has provided treatment or services to me or on my behalf within the past 10 years ("my Providers") to disclose my entire medical record and any other information that may be considered protected health information under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") concerning me to my Representative and its staff, affiliated companies and/or entities, including but not limited to APPs, Examination Management Services (EMSI), Exam One, Express Imaging Services, insurance companies and their re-insurers. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, prescription records and history of prescribed medications, but excludes psychotherapy notes. By my signature below, I acknowledge that any agreements I have made with my Providers that restrict disclosure of my medical records and any associated HIPAA protected health information do not apply for purposes of this authorization and I instruct my Providers to release and disclose my entire medical record without restricae-disclosed and no longer covered by certain federal rules governing privacy and confidentiality of health information. The information contained in these medical and financial records will be held in confidence and may be used only for the purpose of the procurement, or the evaluation or underwriting for the possible procurement, of life, health, long term care, or other insurance products. The contents therein may be reviewed and assessed by a qualified staff consisting of medical directors, underwriters, underwriting assistants, or other related employees involved in the submission, receipt or evaluation of insurance applications or prospective applications of the insurance companies listed below and their re-insurers as well as Shaw American Financial Corp and its staff, employees and affiliated companies.

This authorization shall be valid for twelve (12) months from the date below. A copy of this authorization shall be as valid as the original. I understand that I am entitled to receive a copy of this authorization.

I understand that I may write to my Representative to revoke this authorization and that the revocation will take effect when my Representative receives my written request. I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether I sign the authorization.

I understand that if I refuse to sign this authorization, **Shaw American Financial Corp** may not be able to provide full and complete information about the insurance coverage and its cost that may be available to me. I also understand and acknowledge that each of the insurers listed on this form or to which I may formally apply, may require me to sign a similar authorization used exclusively by such insurer before they will process my application or offer insurance coverage. I understand that my Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization.

I understand that I can revoke this authorization at any time by giving written notice to the **Shaw American Financial Corp** at theaddress shown below. I also understand that my revocation will not affect the rights of any individual who has acted in reliance on the authorization prior to receiving notice of my revocation.

Proposed Insured's Name _____

Proposed Insured's Signature _____

Signed and Dated On _____ At (City, State, Zip Code) _____

Agent/ Witness _____

AIG, Allianz, American General Life Insurance Company, American Mayflower, American National Insurance Companies, Assurity, Athene, AXA Equitable Life Insurance Company, Banner Life Insurance Company, Brighthouse Financial, Cincinnati Life, Companion Life Insurance Company, Fidelity Life, Foresters, Forethought, Genworth Financial Family of Companies, Global Atlantic, John Hancock, Legal and General, Lincoln Financial Group, Mass Mutual, Minnesota Life, Mutual of Omaha Insurance Companies, Nationwide Life Insurance Company, Nationwide Life and Annuity Insurance Company, New York Life, OneAmerica, Principal National Life, Protective Life, Prudential Insurance Company of America, Pruco Life Insurance Company, Pruco Life Insurance Company of New Jersey, Reliastar Life, Security Mutual, Sun Life, Symetra, The Savings Bank Life Insurance Company of Massachusetts, Transamerica Insurance & Investment Group, United Home Life, United of Omaha Life Insurance Company, Voya Financial, William Penn Life Insurance Company of New York, Zurich.

The Shaw Assist program is quick and easy, and we created the list below to help you prepare for our interview with you. Please have this information available when we call to ensure your application can be fully completed and ready for carrier review.

Medical Information

- Names, addresses, phone numbers of doctors or facilities you have visited within the last 5 years
- Reason for visits
- Result of visits
- Any prescriptions you are currently taking (name, dosage and frequency), reason you are taking the medication and who prescribed the medication

HELPFUL TIP: Take a picture of your prescription bottles. This can also help in an emergency especially when you are traveling.

Beneficiary Information

- Name, date of birth, address, phone number, email address and social security number

HELPFUL TIP: Many people like to add their children as contingent beneficiaries but don't have access to their social security numbers. Remember you can always add a contingent beneficiary later when you do have this information.

Business Information

- If this is a business owned policy, the business Tax ID #, assets, liabilities, gross sales, net income after taxes and fair market value of business or a copy of the business' profit and loss statement
- Date business was established, percentage of business owned, any bankruptcy information, company web address

HELPFUL TIP: Carriers can provide coverage in addition to personal insurance when your business is the beneficiary. Limits include up to 10 times your salary for Key Man insurance or your value of ownership in the corporation for Buy-Sell/Stock Redemption or 80% of debt you have signed off on for the benefit of the corporation.

Personal Financial Information

- Estimated annual income and net worth

HELPFUL TIP: There are general guidelines for the financial multiples expected for personal coverage and business coverage. Make sure your estimated income meets the insurance guidelines.